PRINTED: 04/26/2011
FORM APPROVED
OMB NO. 0938 0391

CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES	OMB NO. 0938-039				
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUII	DING	01	COMPLETED	
155657		B. WIN			04/06/2	2011	
			1		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF I	PROVIDER OR SUPPLIER			150 BE	ECHMONT DR		
KINDRE	D TRANSITIONAL (	CARE AND REHAB-HARRISON		CORYE	OON, IN47112		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
K0000							
'	A Life Safety Code Recertification		K(	0000	The statements made on this		
		isure Survey was			plan of correction are not an		
		he Indiana State			admission to and do not	the	
	Department of				constitute an agreement with alleged deficiences herein.		
	•				anoged denoieries ricrem.		
	accordance wit	h 42 CFR 483.70(a).					
	Survey Date: 0	4/06/11					
	   Facility Numbe	r: 010597					
	Provider Numb						
	AIM Number: 200204440						
	, and rainiser.	100201110					
	Surveyor: Lex	Brashear, Life Safety					
	Code Specialist	•					
	Code Specialist	•					
	At this Life Safe	ety Code survey,					
	Kindred Transitional Care and						
	Rehab-Harrison was found not in						
	compliance with Requirements for						
	Participation in						
	Medicare/Medicaid, 42 CFR						
	Subpart 483.70(a), Life Safety						
	•	the 2000 edition of					
	the National Fi						
	· ·	FPA) 101, Life Safety					
		apter 19, Existing					
	Health Care Occupancies and 410						
	IAC 16.2.						
	This one story	facility was					
	· ·	be of Type V (111)					
	I determined to	DC OF TYPE V (TTT)	1		I		I

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

construction and was fully

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

O6XK21

Facility ID:

010597

TITLE

If continuation sheet

PRINTED: 04/26/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		li 1		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01			COMPLETED		
	155657		B. WING				04/06/2011	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-HARRISON			STREET ADDRESS, CITY, STATE, ZIP CODE  150 BEECHMONT DR  CORYDON, IN47112					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		F	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE	
	sprinklered. The facility has a fire							
	alarm system w	vith smoke						
	detection in the corridors, spaces							
	open to the cor	ridors, and all						
	resident sleepir	ng rooms. The						
	facility has a ca	pacity of 92 and						
	had a census o	f 84 at the time of						
	this survey.							
	Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 04/07/11.  The facility was found not in compliance with the							
	aforementioned regulatory requirements as evidenced by the following:							
K0144		spected weekly and bad for 30 minutes per name with NFPA 99.						
SS=F	Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3		K0	144	F01441. No patients were four	t he e	05/06/2011	
					to be affected by the deficier practice.2. All patients have			
					potential to be affected.3. The			
					maintenance supervisor will			
					oversee the installing of a rem- manual stop station located at			
	requires emergency generators				transfer switch for the emerger			
	providing power to emergency lighting systems shall be installed,				generator by an out side			
					contractor. All staff will be	_		
	tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA				inserviced on location of remoinmental stop station after	te		
					installation is complete by the			
					maintenance supervisor.4. The maintenance supervisor will			
	110, 1999 edition, 3–5.5.6				monitor manual stop station weekly with a visual check thru	,		
					masay mara riodal offoot tiff	-		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: O6XK21 Facility ID: 010597

If continuation sheet

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155657	(X2) M A. BUII B. WIN	LDING	NSTRUCTION  01	(X3) DATE COMPL	ETED	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-HARRISON			STREET ADDRESS, CITY, STATE, ZIP CODE 150 BEECHMONT DR CORYDON, IN47112					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE	
	have a remote of a type similar station located premises wher is located outs NFPA 37, Stand Installation and Combustion Errurbines, 1998 requires engine horsepower or provision for sengine at the erremote location practice could in the facility.  Findings include Based on observation of a.m. during a twith the Mainte Environmental and the Admin evidence of a revice was not generator, furt observation of Maintenance Setthe generator with the generator of the ge	d Use of Stationary agines and Gas Bedition, at 8–2.2(c) es of 100 more have hutting down the angine and from a n. This deficient affect all occupants  de:  rvation of generator 04/06/11 at 11:30 our of the facility enance Supervisor, Services Supervisor, istrator in Training, emote shut off			preventative maintenance program and report to the Performance Improvement Committee for 6 months. If af months 100% compliance has been maintained, the Performance Improvement Committee will determine if further monitoring is required. Date of Compliance 5/6/2011	6		

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH ORRECTIVE ACTION SHOULD BE COMPL)  CROSS-REFERENCED TO THE APPROPRIATE  COMPL	AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155657		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		COMI	(X3) DATE SURVEY COMPLETED 04/06/2011	
PREFIX TAG  CEACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  COMPL CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  DAT  DAT				150 BE	ECHMONT DR	CODE	
	PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
Supervisor indicated there was no remote shut off device for the generator.  3.1–19(b)		observation, the Supervisor ind remote shut or generator.	ne Maintenance icated there was no				